

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Item 18 Film 221 10-22-57 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lusby		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Lusby	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First AMELIA Middle D. Last BISHOP		4. DATE OF DEATH Month September Day 25 Year 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Bishop		14. MOTHER'S MAIDEN NAME Audredy Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Audredy Bishop, Lusby, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacillary Dysentery due to Shigella Flexerni 045.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/26/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) A-28-57		22b. DATE THEREOF St. John	
22c. NAME OF CEMETERY OR CREMATORY Lusby		22d. LOCATION (City, town, or county) (State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE P. Z. Sewell, Prince Fred. Md		24a. REC'D BY REGISTRAR 9/30/57	
ADDRESS		24b. REGISTRAR'S SIGNATURE H. W. Ward	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NO. 1000
10-10-10

1. Name of Deceased: _____
2. Sex: _____
3. Age: _____
4. Date of Death: _____
5. Place of Death: _____
6. Cause of Death: _____
7. Manner of Death: _____
8. Signature of Medical Examiner: _____
9. Date of Report: _____

Frank J. [Signature]

RECEIVED
OCT 10 1933
BUREAU V. S.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	
DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
IMMEDIATE CAUSE		UNDERLYING CAUSE	
INTERMEDIATE CAUSE		PREEXISTING DISEASE	
SYMPTOMS		TREATMENT	
HISTORY		FAMILY HISTORY	
SOCIAL HISTORY		HABITS	
PATHOLOGICAL FINDINGS		LABORATORY FINDINGS	
POSTMORTEM FINDINGS		OTHER FINDINGS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

BUREAU V. S.

SEP 30 1957

RECEIVED

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09312

9396

CERTIFICATE OF DEATH

Reg. Dist. No. 52-51

1. PLACE OF DEATH o. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Owings Md. b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b 5 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital				d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Nellie Middle Dobson Last Dobson				4. DATE OF DEATH Month 9 Day 25 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30 1892		9. AGE (In years birthday) yrs. 64	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Maryland			11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Thomas Cox				14. MOTHER'S MAIDEN NAME Liza King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Daughter- Mrs. Gertude Grieson Address Owings, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 490 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 24, 1957 , to Sept 25, 1957 , that I last saw the deceased alive on Sept 25, 1957 , and that death occurred at 1230 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Owings, Md. DATE SIGNED H. W. Ward							
ACTUAL SIGNATURE H. W. Ward				M.D. Owings, Md.			
PHYSICIAN'S NAME (Type) H. W. Ward				Owings, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 27, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Harmony Cemetery		22d. LOCATION (City, town, or county) (State) Near Owings, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Hutchins				ADDRESS Owings, Md.		24a. REC'D BY REGISTRAR DATE 9/26/57	
				24b. REGISTRAR'S SIGNATURE Grace L. Hutchins			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		65		1892		Baltimore		Maryland		United States			
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MANNER OF DEATH		CAUSE OF DEATH		PLACE OF DEATH	
White		White		Roman Catholic		High School		Laborer		Natural		Heart Disease		Home	
DATE OF DEATH		TIME OF DEATH		HOUR		MINUTE		DAY		MONTH		YEAR			
September 28, 1957		10:15 AM		10		15		28		9		1957			
PLACE OF DEATH		CITY		STATE		COUNTRY		MANNER OF DEATH		CAUSE OF DEATH		PLACE OF DEATH			
Home		Baltimore		Maryland		United States		Natural		Heart Disease		Home			
DATE OF DEATH		TIME OF DEATH		HOUR		MINUTE		DAY		MONTH		YEAR			
September 28, 1957		10:15 AM		10		15		28		9		1957			

BUREAU V. S.

SEP 30 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Cabret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Cabret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Republic</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Republic</u>			
c. LENGTH OF STAY IN 1b <u>12 years</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Pardee</u> Last <u>Edmonds</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 27, 1861</u>	
9. AGE (In years lost birthday) <u>96</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. DATE OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Cabret Co., Ind.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Carter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>Mrs Cord Bowen - Port Republic, Ind.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Uremia</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>Sept 15</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. de Villanova</u> M.D.				ADDRESS (Street, city or town, state) <u>50 Remond</u> DATE SIGNED <u>9/15</u>			
PHYSICIAN'S NAME (Type) <u>R. de Villanova</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Sept. 17, 1957</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Middleham Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Lucas - Cabret Co - Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>O. C. Harkness & Son - Mutual, Ind.</u>				24a. REC'D BY REGISTRAR <u>DATE 9/18/57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the funeral director's name and address. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 17 1957

RECEIVED

Item 18 Film 221 10-16-57 ans

10-2-57L

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2

2

VS. A15ME(5)
SM 9/55

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09314

Reg. Dist. No. 51

1. PLACE OF DEATH
a. COUNTY Calvert MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Calvert

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN lb 9 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last MELVILLE K GRAHAM

4. DATE OF DEATH Month Day Year September 12 19 57

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH Nov. 24, 1889

9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY Oil Field Worker 11. BIRTHPLACE (State or foreign country) Michigan 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Graham 14. MOTHER'S MAIDEN NAME Minnie McNeill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 564-10-2471A 17. INFORMANT Address Florence Graham Lusby, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Erythema multiforme bullosa
705.1 DUE TO penicillin sensitivity
Conditions, if any, which gave rise to immediate cause (b) DUE TO
(a), stating the underlying cause last. (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and find that death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE R. S. Fisher M.D. CHIEF MEDICAL EXAMINER ☒ DATE SIGNED 9/13/57

EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 22b. DATE THEREOF Sept 14, 1957 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 22d. LOCATION (City, town, or county) (State) Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. A. Harkness & Son - Mutual, Md. 24a. REC'D BY REGISTRAR DATE 9/13/57 24b. REGISTRAR'S SIGNATURE H. W. Ward

IN ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
SEP 17 1957
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09315

930 CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH COUNTY <u>Cabot</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Lower Marlboro</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Elizabeth Jones</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Cabot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lower Marlboro</u> TOWN STREET ADDRESS (if rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>ELIZABETH</u> (First) <u>A.</u> (Middle) <u>JONES</u> (Last)				4. DATE OF DEATH (Month) <u>Sept</u> (Day) <u>14</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 9, 1867</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Alexander H. Hutchinson</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Ryan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Reuben Jones, Lower Marlboro Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 904.0 IMMEDIATE CAUSE (A) <u>Cardio Vascular renal disease</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Fracture of hip</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Fall</u> STATING UNDERLYING CAUSE LAST.				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>12 wks</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>July 8, 1957</u>				19b. MAJOR FINDINGS OF OPERATION <u>Fracture of left hip</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, of injury street office bldg, etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>July 8, 1957 Lower Marlboro Cabot Md</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>July 11, 1957 4P</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall in house</u>			
22. I hereby certify that I attended the deceased from <u>July 13, 1957</u> , to <u>Sept 13, 1957</u> , that I last saw the deceased alive on <u>Sept 13, 1957</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. W. Ward</u>				ADDRESS (Street, city, town, state) <u>Lower Md</u>		DATE SIGNED <u>9/14/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 16, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Lower Marlboro</u>		LOCATION (City, town, or county) (State) <u>Lower Marlboro Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Grace L. Hutchinson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm H. Hutchinson</u>		ADDRESS <u>Lower Md</u>	
DATE <u>9/14/57</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF DEATH

6. CAUSE OF DEATH

7. PLACE OF DEATH

BUREAU V. 3

SEP 18 1957

RECEIVED

9310

CERTIFICATE OF DEATH

09316 51

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital		d. STREET ADDRESS 505 -12th. St., S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle R. Last Moffett		4. DATE OF DEATH Month 9 Day 15 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 16, 1883
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Sullivan		14. MOTHER'S MAIDEN NAME Lucy B. Saul Sullivan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Son, Richard Moffett		Address Dares Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure, 4341 DUE TO (Sudden death) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on Sept 15 , 19 57 , and that death occurred at 8:40 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) St. Thomas DATE SIGNED 9/15/57 ACTUAL SIGNATURE Robert de Villarreal M.D. PHYSICIAN'S NAME (Type) Robert de Villarreal			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-18-57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., Washington, D.C.		24a. REC'D BY REGISTRAR SEP 17 1957	
24b. REGISTRAR'S SIGNATURE H. H. Hardy			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

RECEIVED
 SEP 17 1957
 BUREAU V. S.

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Sex		Race	
Marital Status		Occupation	
Cause of Death		Place of Death	
Time of Death		Signature of Physician	
Signature of Registrar		Signature of Coroner	

9311 CERTIFICATE OF DEATH

09317

Reg. Dist. No. 51

1. PLACE OF DEATH o. COUNTY <u>Cabnet</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cabnet</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Coster</u>				c. LENGTH OF STAY IN 1b <u>7 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2. Coster</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>MORGAN</u> Last <u>MORGAN</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1884</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>15</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Johnstown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Morgan</u>				14. MOTHER'S MAIDEN NAME <u>Martha Somerville</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>577-07-4168</u>		17. INFORMANT Address <u>Pauline Morgan - Coster, Ind</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epithelioma of hip</u> <u>191X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of hip</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Sept 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 22</u> , 19 <u>57</u> , and that death occurred at <u>3 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Page C. Jett</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>9/24/57</u>			
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT M.D.</u>				<u>PRINCE FREDERICK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 25, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>A. A. Harkness & Son - Mutual, Ind.</u>				24a. REC'D BY REGISTRAR DATE <u>9/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 10-1
 CERTIFICATE OF DEATH

PLACE OF DEATH HOME		PLACE OF BIRTH HOME	
DATE OF DEATH SEP 26 1957		DATE OF BIRTH SEP 26 1957	
TIME OF DEATH 10:00 AM		TIME OF BIRTH 10:00 AM	
NAME OF DECEASED JOHN J. BROWN		NAME OF BIRTH JOHN J. BROWN	
SEX MALE		SEX MALE	
RACE WHITE		RACE WHITE	
OCCUPATION LABORER		OCCUPATION LABORER	
MARITAL STATUS MARRIED		MARITAL STATUS MARRIED	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. J. BROWN		SIGNATURE OF PHYSICIAN J. J. BROWN	
SIGNATURE OF REGISTRAR J. J. BROWN		SIGNATURE OF REGISTRAR J. J. BROWN	

RECEIVED
 SEP 26 1957
 BUREAU V. 2

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

09318

Reg. Dist. No. 51

9312

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Prince Fred,</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Prince Fred, md</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>1</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles</u>		(Middle) <u>H.</u>		(Last) <u>Stewart</u>		(Month) <u>9</u> (Day) <u>1</u> (Year) <u>1957</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb 1,</u>	9. AGE last birthday <u>93</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days		IF UNDER 24 HRS. Hours <u>4</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles H Stewart</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Florence Duke Prince Fred, md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Cornary occlusion</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>Sept</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 3</u> , 19 <u>57</u> , and that death occurred at <u>4:55</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>R. W. Ward</u> M.D.		DATE THEREOF <u>9-3-57</u>		NAME OF CEMETERY OR CREMATORY <u>mt. Olive</u>		LOCATION (City, town, or county) (State) <u>Prince Fred, md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR DATE <u>9-3-57</u>		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. Z. Sewell</u>		ADDRESS <u>Prince Fred, md</u>	

CERTIFICATE OF DEATH

1-10-1918

TO WHOM THESE PRESENTS SHALL COME

MARYLAND

County of *Calvert*

State of *Maryland*

City of *Baltimore*

Age *45*

Sex *Male*

Color *White*

Married *Yes*

Occupation *Teacher*

Place of Birth *Germany*

Usual Residence *Baltimore*

Place of Death *Baltimore*

Day of Death *Sept 5*

Year of Death *1918*

Time of Death *10:30 AM*

Place of Death *Home*

Cause of Death *Heart Disease*

Immediate Cause *Myocardial Infarction*

Underlying Cause *Arteriosclerosis*

Contributing Cause *Overwork*

Medical History *None*

Postmortem Examination *Not Made*

Signature of Physician *J. H. Smith*

Signature of Coroner *W. H. Jones*

Signature of Registrar *M. A. Brown*

Signature of Minister *R. L. White*

Signature of Undertaker *C. D. Green*

Signature of Burial Society *F. G. Black*

Signature of Cemetery *H. I. Blue*

Signature of Interment *J. K. Red*

Signature of Burial Society *L. M. Yellow*

Signature of Interment *N. O. Purple*

Signature of Burial Society *P. Q. Grey*

Signature of Interment *R. S. White*

Signature of Burial Society *T. U. Black*

Signature of Interment *V. W. Green*

Signature of Burial Society *X. Y. Blue*

Signature of Interment *Z. A. Red*

Signature of Burial Society *B. C. Yellow*

Signature of Interment *D. E. Purple*

Signature of Burial Society *F. G. Grey*

Signature of Interment *H. I. White*

Signature of Burial Society *J. K. Black*

Signature of Interment *L. M. Green*

Signature of Burial Society *N. O. Blue*

Signature of Interment *P. Q. Red*

Signature of Burial Society *R. S. Yellow*

Signature of Interment *T. U. Purple*

Signature of Burial Society *V. W. Grey*

Signature of Interment *X. Y. White*

Signature of Burial Society *Z. A. Black*

Signature of Interment *B. C. Green*

Signature of Burial Society *D. E. Blue*

Signature of Interment *F. G. Red*

Signature of Burial Society *H. I. Yellow*

Signature of Interment *J. K. Purple*

Signature of Burial Society *L. M. Grey*

Signature of Interment *N. O. White*

Signature of Burial Society *P. Q. Black*

Signature of Interment *R. S. Green*

Signature of Burial Society *T. U. Blue*

Signature of Interment *V. W. Red*

Signature of Burial Society *X. Y. Yellow*

Signature of Interment *Z. A. Purple*

Signature of Burial Society *B. C. Grey*

Signature of Interment *D. E. White*

Signature of Burial Society *F. G. Black*

Signature of Interment *H. I. Green*

Signature of Burial Society *J. K. Blue*

Signature of Interment *L. M. Red*

Signature of Burial Society *N. O. Yellow*

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Signature of Burial Society *R. S. Grey*

Signature of Interment *T. U. White*

Signature of Burial Society *V. W. Black*

Signature of Interment *X. Y. Green*

Signature of Burial Society *Z. A. Blue*

Signature of Interment *B. C. Red*

Signature of Burial Society *D. E. Yellow*

Signature of Interment *F. G. Purple*

Signature of Burial Society *H. I. Grey*

Signature of Interment *J. K. White*

Signature of Burial Society *L. M. Black*

Signature of Interment *N. O. Green*

BUREAU V. S.

SEP 5 1918

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9313

CERTIFICATE OF DEATH

0931957
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cabot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN TB <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabot County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Walter</u> First <u>Hance</u> Middle <u>Williams</u> Last				4. DATE OF DEATH Month <u>Sept.</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 15, 1898</u>	
9. AGE (In years lost birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>0</u> Hours <u>0</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman at Beach</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Watchman</u>		11. BIRTHPLACE (State or foreign country) <u>Cabot County, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Willis Williams</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hance</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>220-16-8488</u>			
17. INFORMANT <u>Hance Williams, Jr.</u>				Address <u>Owings, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident.</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C.V. Disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>15 Sept</u> , 19 <u>57</u> , to <u>15 Sept</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 Sept</u> , 19 <u>57</u> , and that death occurred at <u>5:39</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. J. Weems</u>				ADDRESS (Street, city or town, state) <u>Huntingtown</u> DATE SIGNED <u>9/15/57</u>			
PHYSICIAN'S NAME (Type) <u>B. J. WEEMS</u>				ADDRESS <u>HUNTINGTOWN</u> DATE SIGNED <u>9/15/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 18, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cmn.</u>		22d. LOCATION (City, town, or county) (State) <u>Port Republic, Cabot Co - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son - Mutual, Md</u>				24a. REC'D BY REGISTRAR <u>H. W. Ward</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 2

SEP 18 1957

RECEIVED